Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
THE METHODIST HOSPITAL
PO BOX 1866
FORT WORTH TX 76101

Respondent Name
ASSOCIATION CASUALTY INSURANCE

MFDR Tracking Number
M4-05-1534-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
#53

MFDR Date Received
October 28, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Adjuster denied claim because this was preauthorized for outpatient and turned out to be inpatient. Adjuster was aware of the situation because she called the hospital. We believe this bill she [sic] be paid because adjuster knew the case and knew this inpatient care."

Amount in Dispute: $9936.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated November 13, 2004: The above referenced health care provider billed $47,768.75, for dates of service 4/29/04 through 5/11/04 for a twelve-day length of stay. The provider was reimbursed a total of $3480.00…The provider was paid at the TWCC ACIHFG Inpatient Guidelines for a medical stay, days 4/29/04 – 5/03/04, a total of 5 days. Preauthorization for these DOS was obtained. …The Methodist Hospital, is in fact owed an additional amount per day for days 4/29/04 – 5/03/04. As it was a 'surgical inpatient' stay. Inpatient stay for days 5/04/04 – 5/12/04, were denied as 'preauthorization required by not requested.' The facility did not seek authorization for any inpatient stay extension, or for the surgery performed on 5/5/04...A supplemental payment will be made in the amount of $1240.00 for the DOS, 4/29/04 – 5/03/04."

Response Submitted by: Association Casualty Insurance

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 29, 2004 through May 3, 2004 May 4 through 11, 2004	Inpatient Hospital Services	$9,936.00	$870.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 521 – Inpatient medical per diem allowance
- F – F-Fee Guideline MAR reduction
- A – A-preauthorization required/not requested
- Note: surgery was to be performed no later than 04/29/04, does not appear an auth. was obtained for extension on time allowance, nor for extended hosp. stay.

Issues

1. Was pre-authorization obtained for the disputed dates of service?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Reimbursement is established pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was twelve days; however, documentation supports that the Carrier pre-authorized a length of stay of five days in accordance with 28 Texas Administrative Code Rule §134.600. Consequently, the per diem rate allowed is $1,118.00 for the five authorized days which results in an allowable amount of $5,590.00.

    - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $321.50 for Ciprofloxacin 400mg D5W 200ml and $266.50 for a PCA pump. The requestor did not submit documentation to support what the cost to the hospital was for these pharmaceuticals. For that reason, reimbursement for these items cannot be recommended.

Conclusion

The division concludes that the total allowable for this admission is $5,590.00. The respondent issued payment in the amount of $4,720.00. Based upon the documentation submitted, additional reimbursement in the amount of $870.00 is recommended

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of $870.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

		October 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.